

LOUDOUN COUNTY GOVERNMENT
Americans with Disabilities Act (ADA)
Reasonable Accommodation Request Form

To complete this form, you will need to discuss the essential functions of your position with your supervisor and discuss accommodations that would assist in your work performance. You may also contact the Human Resources Division if you have any questions regarding the ADA or the process for requesting a reasonable accommodation.

In order to determine whether you are eligible for an accommodation, Human Resources staff may request documentation of your medical condition in the form of a healthcare provider statement describing the medical condition that necessitates the position accommodation. The medical information completed by your healthcare provider will be confidential but may be shared with individuals who have a legitimate operational need to know this information. You consent to this sharing of information by signing the release below.

Employee Information

Date of Request

Employee's Name (Please print)

Job Title/Position Number

Department/Division

Phone Number

Supervisor

Phone Number

Reason for Request:

1. Describe in detail the accommodation you are requesting and attach a copy of your current performance plan.

Employee Signature

I certify that the information given on this form is true. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment.

Employee Signature Date

Release of Information

I authorize my health care provider (s) _____ to release information to and, if necessary, speak with the Loudoun County Government Human Resources staff about my medical condition for the purpose of determining appropriate job accommodations(s) for my condition. My medical information is confidential and therefore will be shared only with individuals on a need to know basis.

Employee Signature Date

Received in Human Resources by:

HR Staff Signature Date